

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/11/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155205</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GREENCROFT HEALTHCARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1225 GREENCROFT DR</b> <b>GOSHEN, IN 46527</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{K 000}	<p>INITIAL COMMENTS</p> <p>A Post Survey Revisit (PSR) to the Initial Life Safety Code Certification and State Licensure Survey for a new addition with 60 certified Comprehensive beds on 08/13/15 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 09/09/15</p> <p>Facility Number: 000112 Provider Number: 155205 AIM Number: 100288710</p> <p>At this PSR survey, the addition of Greencroft Healthcare which will be certified, the first and second floor, was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety From Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and with 410 IAC 16.2-3.1-19, Environment and Physical Standards of the Indiana Health Facilities Rules for Comprehensive care facilities.</p> <p>This two story facility was determined to be of Type II (111) construction and fully sprinklered. A 2-hour fire wall is provided on each side of the corridor dividing the facility into two separate buildings. The new building is subdivided into two smoke compartments on both floors. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The new addition has a capacity of 60</p>	{K 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{K 000}	<p>Continued From page 1</p> <p>Comprehensive beds and had a census of 0 at the time of this visit.</p> <p>The facility has elected to utilize a Categorical Waiver pertaining to cooking facilities which allows certain types of alternative kitchen cooking arrangements.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review completed 09/10/15 - DA</p>	{K 000}			